Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

THOMAS CATOLDI, DO
3100 TIMMONS LANE, STE 250
HOUSTON, TX 77027

Respondent Name

FARMINGTON CASUALTY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-11-3897-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $315.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider herein billed for more than three body areas, and consequently, the Carrier reimbursed for only three body areas per the Rule….The ROM for the hips was not separately reimbursed, as it constituted a fourth body area. When combined with the $350.00 reimbursement for the MMI evaluation itself, the total reimbursement for CPT code 99456-W5-WP was properly calculated and reimbursed as $950.00 . The provider is not entitled to additional reimbursement for this CPT code. As to CPT code 99080-73, the work status report, the Provider is not entitled to separate reimbursement for the completion of the report…"

Response Submitted by: Travelers (Farmington Cas.), 1501 S. Mopac Expwy, STE A-320, Austin, TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 13, 2011	99456-W5-WP and 99080-73	$315.00	$300.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits dated June 02, 2011
   - W1 – WORKERS COMPENSATION STATE F/S ADJ. REIMBURSEMENT BASED ON MAX ALLOWABLE FEE FOR THIS PROC. BASED ON MEDICAL F/S, OR IF ON IS NOT SPECIFIED, UCR FOR THIS ZIP CODE AREA.
   - GL33 – B15 – THIS SERVICE/PROCEDURE REQUIRES THAT A QUALIFYING SVC/PROC BE RECEIVED AND COVERED. WORK-RELATED OR MEDICAL DISABILITY EVALUATION SERVICES (CPT 99455 OR 99456) SHOULD BE REPORTED WITH CODE 99080.

   Explanation of benefits dated June 15, 2011
   - Z12F – 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY. AFTER CAREFULLY REVIEWING THE RESUBMITTED INVOICE, ADDITINOAL REIMBURSEMENT IS NOT JUSTIFIED.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to additional reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor submitted a billing for the DD examination Maximum Medical Improvement/Impairment Rating (MMI/IR) services for 5 body area/unit in box 24G of the CMS-1500 for $1,250.00 and billed with CPT code 99456-W5-WP. Review of the documentation supports that MMI was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. The lumbar spine and bilateral hips (spine and pelvis), bilateral ankles/foot/knees (lower extremity), right wrist/hands (upper extremity), head contusion, facial contusion, and leg strain/contusion are the areas claimed as rated which are more than the 5 billed in box 24G. The carrier, in its response refers to three body areas which is in relation to 3 musculoskeletal body areas and does not prohibit billing for additional non-musculoskeletal body areas/conditions. Per Texas Administrative Code §134.204(j)(4)(C)(i)(I), lumbar, cervical, thoracic and pelvis/hip are part of one body area, the spine. Documentation supports a Range of Motion (ROM) IR method on the bilateral knees and ankle/foot (lower extremities) for a MAR of $300.00 per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a) and $150.00 for the IR to the upper extremities ROM to right wrist/hand per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(b). The IR per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the three non musculoskeletal conditions of leg strain/contusion, head contusion, and facial contusion is per 28 Texas Administrative Code §134.204 (j)(4)(D)(iv) and (v) and has a MAR of $150.00 x 3 = $450.00. The combined MAR for the MMI and IR exams is $1,400.00. The respondent has reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP. Regarding CPT code 99080-73, 28 Texas Administrative Code §134.204 states in part (k) that reimbursement "shall include Division-required reports." Therefore, no separate reimbursement is recommended for this report charge.
2. The respondent has already reimbursed the amount of $950.00 for the disputed CPT code 99456-W5-WP and none is due for 99080-73. Therefore, the requestor is entitled to additional reimbursement of $300.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $300.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $300.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	February 13, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.
Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.